Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
HILL COUNTRY PAIN ASSOCIATES PA

Respondent Name
TRAVELERS INDEMNITY CO OF CONNECTICUT

MFDR Tracking Number
M4-15-0436-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
September 29, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On 1/10/13, Dr. Charles Murphy with Hill Country Pain Associates, PA (HCPA) percutaneuously placed two Medtronic 8-electrode leads into [injured employee] epidural space (attachement A). Therefore, HCPA billed 16 units of HCPCS code L8680 (implantable neurostimulator electrode, each) (attachment B). The 2013 DMEPOS Fee Schedule for Texas pricers L8680 in the amount of $432.00 per electrode (attachement C). In accordance with 28 Tex. Admin. Code § 134.203z9(d)(1) 125% of the fee listed for the code in the Medicare DMEPOS fee scheduled should be included in pricing. Therefore, L8680 should be reimbursed at $540.00 per electrode, thus L8680 ($5400) x 16 = $8640.00. Traveler's only paid $977.50 for the total number of units billed and is stating no additional payment due.

Our first denial from Travelers was dated 4/23/13 (attachement D). Travelers denied L8680 x 16 units stating reason code 16 – Based on information we recommend further payment and 8 – please submit copy of invoice … We appealed the insufficient payment clearly stating additional payment was due, however again after many attempts on our end to have Travelers acknowledge and process our appeal correctly, on 8/1/14 we contacted Travlers and spoke with Alex Ref #148669470 and were told lead were processed correctly and no additional payment would be issued."

Amount in Dispute: $7,662.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "THIS REQUEST FOR MEDICAL FEE DISPUTE RESOLUTION SHOULD BE DISMISSED IN ACCORDANCE WITH RULE 133.307(f)(3)(D), AS THE PROVIDER FAILED TO TIMELY FILE THE REQUEST WITHIN ONE YEAR OF TH E DATE OF SERVICE AS REQUESTED BY RULE 133.3607(c)(1)."

Response Submitted by: TRAVELERS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 10, 2013	CPT Code L8680	$7,662.50	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 16 – Based on information, we recommend further payment
   - 8 – Please submit copy of invoice
   - W3 – no reason given

Issue

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The date of the services in dispute is January 10, 2013. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on September 29, 2014. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute, as addressed in 28 Texas Administrative Code §133.307(c)(1) and (c)(1)(A). For that reason, the merits of the issues raised by the parties to this dispute have not been addressed.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	2/27/15 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.